Department of HUMAN SERVICES

Health Home Learning Collaborative

Team – Based Care

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This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid Enterprise

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Learning Objectives

- Review definitions
  - Team – based care
  - Patient – centered care
- Discuss framework of team – based care
  - Why we use team – based care

PEER TO PEER DISCUSSION #1

- Identify team – based care:
  - Roles and responsibilities
  - Components
  - Values

PEER TO PEER DISCUSSION #2

Learning Objectives

- Discuss value of integrating physical health and behavior health
  - Processes
  - Workflows
- Share use of six Core Health Home Services to impact our members

PEER TO PEER DISCUSSION #3

- Wrap – up
  - Q & A
  - Comments

Why team – based care in a patient – centered environment??

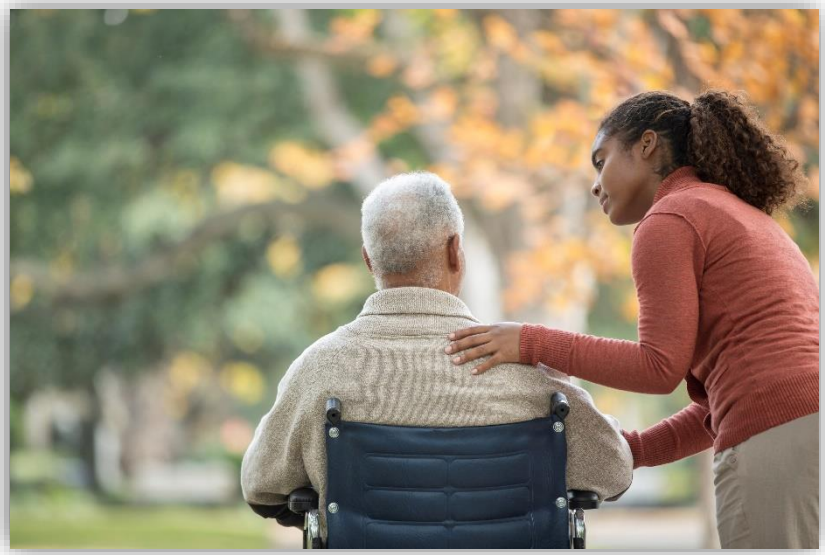
DEFINITIONS

Team – based care: Definition

"Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high quality care." (Mitchell et al., 2012, p. 5)

trustees.aha.org

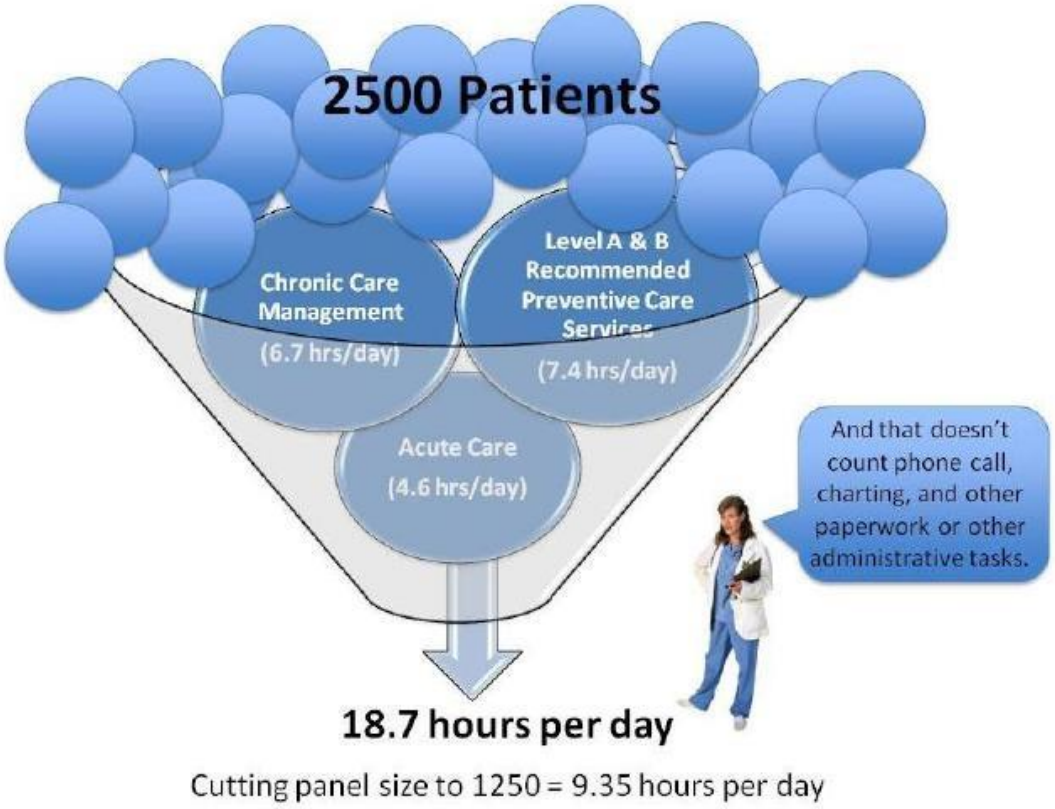
Person – centered care: Definition



"Patient-centered care is defined as care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. Promoting patient-centered and team-based care is important to providing high – quality care."

National Academies Press (US); 2013 Dec 27.

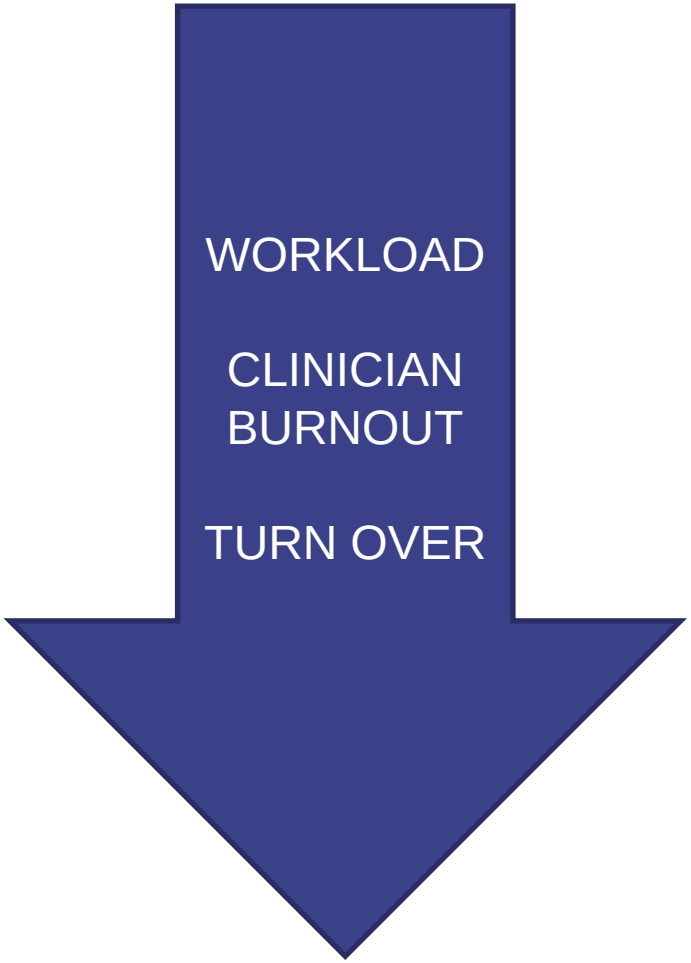
Perspective!



Based on data from: Yarnall KSH, Pollak KI, Østbye T, et al. Primary care: is there enough time for prevention? Am J Public Health. 2003 Apr;93:635-64; and Østbye T, Yarnall KSH, Krause KM, et al.

Why Should We Practice in Teams?

TEAM PRACTICE



SOURCE: Implementing Optimal Team-Based Care to Reduce Clinician Burnout - National Academy of Medicine (nam.edu)

Steps to Optimal Team – Based Care Framework

RESOURCES:
https://nam.edu/perspectives-2012-core-principles-values-of-effective-team-based-health-care/
https://edhub.ama-assn.org/steps-forward/module/2702513
https://www.nap.edu/read/25983/chapter/9

DISCUSSION WITH PEERS

Define the roles of the following members on your team:

- ❑ Nurse Care Manager
- ❑ Care Coordinator
- ❑ Peer/Family Support Specialist

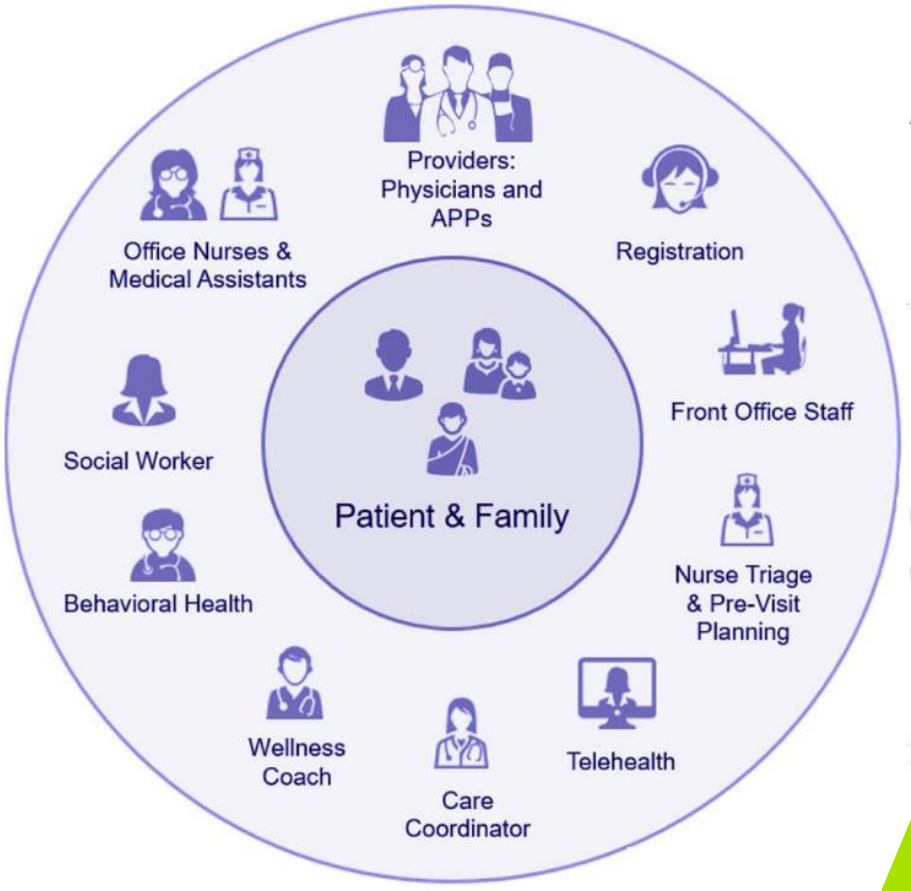
GIVE AN EXAMPLE OF A TIME YOU WORKED IN A TEAM SETTING AND IT WAS SUCCESSFUL....UNSUCCESSFUL

- ❑ What were you doing?
- ❑ What was your goal?
- ❑ What was the outcome?

TEAM – BASED CARE

ROLES, RESPONSIBILITIES, COMPONENTS AND VALUES

TEAM – BASED CARE



ROLES

ESSENTIAL COMPONENTS

CORE VALUES

KEY PLAYERS

The '**member**' refers to the member **themselves** plus any family members or caregivers the member wishes to be involved.

The '**provider team**' is a group of practitioners who identify as members of a team AND work together to provide care for a panel or case load of members.

- Physicians, Therapists
- Nurses, Nurse Care Manager
- PAs, ARNPs
- Care Managers, Health Coaches
- Social Workers
- Peer/Family Support Specialists
- Receptionists

"Patient – centered care teams are *customized* teams that form to provide care for the *individual* member.

The MEMBER is included in this team!

KEY ROLE OF MEMBER AND FAMILY:
SHARED DECISION - MAKING

PARTICIPATION

- Group Education programs
- Participate in status reports and/or discharge planning process
- Care Planning

PRACTICE

- Self – management
- Use of tools to monitor own health

EXPRESS

- Values
- Preferences
- Cultural Norms and Needs
- End of life desires

COLLABORATE

- Improvement partner on team
- Share knowledge with team

PLAN

- Plan and evaluate services
- Set and endorse treatment goals

Essential Components

- Facilitate/coordination of care support among various team members
- Enhance use of evidence-based guidelines by team members
- Establish mechanisms to monitor member progress
  - Schedule additional visits if needed
- Engage/Educate member in self – management
  - Medication
  - Adherence support: medication/treatments

Team – based care activities

- Member/family are central to and actively engaged members of health care team.
- Shared vision
- Role clarity
- Accountability
- Effective communication
- Team leadership

Guiding Principles

Source: Schottenfeld Lisa, Petersen Dana, Peikes Deborah, Ricciardi Richard, Burak Hannah, McNellis Robert, Genevro Janice. Creating Patient-Centered Team-Based Primary Care. AHRQ. 2016; 16-0002-EF

Core Values for Team – Based Care

DISCIPLINE	- Carry out roles/responsibility even when *not* convenient - Seek out/share information even when *not* comfortable
CREATIVITY	- Be excited - See errors and unanticipated outcomes - See potential opportunities to learn and improve
HUMILITY	- Recognize differences in training - See others as human- mistakes happen!
CURIOSITY	- Seek out and reflect on lessons learned - Practice continuous improvement-
HONESTY	- Open communication within the team - Practice transparency

Utilize – Train Team Members

Remember importance of:

- Front desk staff
- Support staff

Standardize work processes:

- Engage ALL members in workflow redesign
- Standard process in place
- Clarify roles
- Cross – train staff


Now it's your turn!

Put bread in toaster

Push bread down and press button

Bread pops up

Is the toast brown enough?

NO

YES

Eat your toast.

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Processes and Workflows

Integrating Physical and Behavioral Health

Specific Processes & Workflows

- Support regular screening of behavioral health needs
- Behavioral interventions to occur at time need is identified
- Support quick consultations, warm handoffs
- Triage processes allow referrals to specialty services
- Shared medical records
- Proactive outreach and follow – up
- Track member progress and adjust treatments as need
- Protocols for monitoring/tracking children/adults with behavioral health needs
- Protocols for coding and billing services

Source: Provider- and Practice-Level Competencies for Integrated Behavioral Health in Primary Care: A Literature Review

Six Core Health Home Measures

IMPACTING OUR MEMBERS

Comprehensive Care Management

Provide for all member health care needs:

- All stages of life
- Acute care
- Chronic care
- Preventive services
- End – of – Life care

Develop/maintain continuity of care document:

- All medical needs
- Treatment plans
- Medication list

Implement screening tools:

- Behavioral health treatments
- Physical healthcare needs

CARE COORDINATION

SOURCE: Visiting Nurse Services of New York

Assist members with

- Medication adherence
- Appointments
- Referrals
- Health insurance coverage
- Transition of care
- Wellness education
- Health support or modification
- Behavior changes

Health information Technology (HIT)

- Mental/behavioral health
- Oral health
- Long-term care
- Chronic disease management
- Recovery services
- Social health services
- Behavior modification interventions
- Transitional care
- Member follow – up

HEALTH PROMOTION

Coordinate/Provide behavior modification interventions

- Support health management
- Improve disease outcomes
- Disease prevention
- Safety
- Healthy lifestyle

Clinical decision support

- Workflow processes

Implement diabetes disease management program

Comprehensive Transitional Care (Practitioner, Nurse Care Coordinator [CCHH], Nurse Case Manager [IHH])	Individual & Family Support (Health Coach, CCHH; Peer and Family Support Specialist, IHH)	Referral to Community & Social support services (Nurse Care Coordinator, CCHH; Nurse Case Manager, IHH)
Behavior Modification interventions - Support health management - Improve disease outcomes - Disease prevention - Promote healthy lifestyle Clinical decision support within practice workflow Implement Diabetes Disease management program Transitions of care support - Inpatient to other settings - Receive updated information through CCD related to transition - Short- and long-term care coordination of services - Personal contact with member	Assist with: - Alternatives to ED or hospital care - Crisis plan / Action planning - Monitor for crisis escalation/need for prevention - Member follow – up after ED or hospital discharge Communicate with member/family - Assessment of care decisions Advocated for member/family Assist with obtaining/adhering to medication and other treatments Assess member's physical and social environment	Coordinate or Provide: - Recovery services - Social health services

What does this look like as a team member and as a health home?

*Discussion with Peers

- Share with your group what one thing you do **well**
- One thing you would like to **improve.**
- Be ready to share information you have learned from your peers and be prepared to create an **action plan** with your health home team members that illustrates use of the 6 core health services in a team – based care model.
- Each health home will give a brief report out to the large group!

QUESTIONS - COMMENTS

Thank you!